

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	53,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	53,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,815	595	7,636	11,046	8
9	SNF/PED					9
10	ICF	19,474	14,505	1,103	35,082	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,289	15,100	8,739	46,128	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.92%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 145 and days of care provided 7,636

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/08 Fiscal Year: 12/31/08

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	345,243	29,234	13,317	387,794		387,794		387,794		1
2	Food Purchase		226,019		226,019		226,019	(11,586)	214,433		2
3	Housekeeping	251,705	28,715		280,420		280,420	331	280,751		3
4	Laundry	72,949	12,707		85,656		85,656		85,656		4
5	Heat and Other Utilities			234,837	234,837		234,837	4,893	239,730		5
6	Maintenance	38,695		133,309	172,004		172,004	33,555	205,559		6
7	Other (specify):* Mgmt Co. Alloc. Bene							3,644	3,644		7
8	TOTAL General Services	708,592	296,675	381,463	1,386,730		1,386,730	30,837	1,417,567		8
	B. Health Care and Programs										
9	Medical Director			46,875	46,875		46,875		46,875		9
10	Nursing and Medical Records	2,696,754	160,888	111,934	2,969,576		2,969,576	12,918	2,982,494		10
10a	Therapy			714,304	714,304		714,304		714,304		10a
11	Activities	215,010	23,935	6,603	245,548		245,548		245,548		11
12	Social Services	108,284		7,421	115,705		115,705		115,705		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt Co. Alloc. Bene							2,175	2,175		15
16	TOTAL Health Care and Programs	3,020,048	184,823	887,137	4,092,008		4,092,008	15,093	4,107,101		16
	C. General Administration										
17	Administrative	100,540		843,966	944,506		944,506	(803,559)	140,947		17
18	Directors Fees										18
19	Professional Services			140,107	140,107		140,107	2,900	143,007		19
20	Dues, Fees, Subscriptions & Promotions			19,303	19,303		19,303	3,193	22,496		20
21	Clerical & General Office Expenses	225,952	27,451	19,940	273,343		273,343	290,224	563,567		21
22	Employee Benefits & Payroll Taxes			628,802	628,802		628,802	11,582	640,384		22
23	Inservice Training & Education			1,349	1,349		1,349		1,349		23
24	Travel and Seminar			7,505	7,505		7,505	423	7,928		24
25	Other Admin. Staff Transportation							14,431	14,431		25
26	Insurance-Prop.Liab.Malpractice			148,216	148,216		148,216	2,222	150,438		26
27	Other (specify):* Mgmt Co. Alloc. Bene							43,700	43,700		27
28	TOTAL General Administration	326,492	27,451	1,809,188	2,163,131		2,163,131	(434,884)	1,728,247		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,055,132	508,949	3,077,788	7,641,869		7,641,869	(388,954)	7,252,915		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Lexington of Elmhurst

#0037317

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			97,567	97,567		97,567	170,989	268,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,846	19,846		19,846	563,648	583,494			32
33	Real Estate Taxes							65,119	65,119			33
34	Rent-Facility & Grounds			1,000,015	1,000,015		1,000,015	(997,299)	2,716			34
35	Rent-Equipment & Vehicles			44,093	44,093		44,093	3,036	47,129			35
36	Other (specify):*											36
37	TOTAL Ownership			1,161,521	1,161,521		1,161,521	(194,507)	967,014			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		242,532	1,816	244,348		244,348		244,348			39
40	Barber and Beauty Shops			22,954	22,954		22,954		22,954			40
41	Coffee and Gift Shops			2,350	2,350		2,350		2,350			41
42	Provider Participation Fee			79,605	79,605		79,605		79,605			42
43	Other (specify):* Non-allowable cost			47,161	47,161		47,161	(47,161)				43
44	TOTAL Special Cost Centers		242,532	153,886	396,418		396,418	(47,161)	349,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,055,132	751,481	4,393,195	9,199,808		9,199,808	(630,622)	8,569,186			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,508)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,690	30		9
10	Interest and Other Investment Income	(304,346)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,534)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,325)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,535)	43		24
25	Fund Raising, Advertising and Promotional	(8,462)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,838)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See sch 5A</u>	(76,483)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (415,345)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(215,277)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (215,277)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (630,622)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Elmhurst

ID# 0037317
 Report Period Beginning: 01/01/2008
 Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (40,619)	21	1
2	Labs-Part A	(4,583)	43	2
3	X-Rays-Part A	(6,378)	43	3
4	Miscellaneous Income	(164)	21	4
5	Chamber of Commerce Dues	(225)	20	5
6	Trust Fees	(50)	43	6
7	Collections	(9,661)	19	7
8	Out of period legal	(5,859)	19	8
9	Additional Marketing Salary	(8,069)	10	9
10	Non-allowable accounting	(875)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(76,483)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Elmhurst		
				II Ltd. Ptsp.	Elmhurst	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 1,000,015	Sambell of Elmhurst II Limited Partnership	**	\$	\$ (1,000,015)	1
2	V	19 Professional Fees		Sambell of Elmhurst II Limited Partnership	**	200	200	2
3	V	21 Office supplies		Sambell of Elmhurst II Limited Partnership	**	105	105	3
4	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	133,399	133,399	4
5	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	851,571	851,571	5
6	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	3,050	3,050	6
7	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	62,815	62,815	7
8	V	43 State replacement tax		Sambell of Elmhurst II Limited Partnership	**	2	2	8
9	V	43 Trust fees		Sambell of Elmhurst II Limited Partnership	**	50	50	9
10	V							10
11	V							11
12	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				12
13	V			of Sambell of Elmhurst II Limited Partnership				13
14	Total		\$ 1,000,015			\$ 1,051,192	\$ * 51,177	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.

Provider # 0037317

1/1/08 - 12/31/08

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	16.66%
John Samatas Discretionary Trust	16.67%
Cynthia Thiem Discretionary Trust	16.67%
David S. Bell Revocable Trust	12.50%
Jeffrey J. Bell Revocable Trust	12.50%
Lawrence W. Bell Revocable Trust	12.50%
David S. Bell 2001 Trust	4.16%
Jeffrey J. Bell 2001 Trust	4.17%
Lawrence W. Bell 2001 Trust	4.17%

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 331	\$	331	15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	4,071		4,071	16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	103		103	17
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	719		719	18
19	V	6 Management allocation - salaries		Royal Management Corp.	**	29,833		29,833	19
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,540		3,540	20
21	V	6 Scavenger & exterminating		Royal Management Corp.	**	182		182	21
22	V	6 Security service		Royal Management Corp.	**				22
23	V	7 Management allocation - employee benefits		Royal Management Corp.	**	3,644		3,644	23
24	V	10 Medical consultant		Royal Management Corp.	**	3,179		3,179	24
25	V	10 Management allocation - salaries		Royal Management Corp.	**	17,808		17,808	25
26	V	15 Management allocation - employee benefits		Royal Management Corp.	**	2,175		2,175	26
27	V	17 Management allocation - salaries		Royal Management Corp.	**	40,407		40,407	27
28	V	19 Computer consultant & supplies		Royal Management Corp.	**	15,242		15,242	28
29	V	19 Professional fees		Royal Management Corp.	**	3,853		3,853	29
30	V	20 Dues & subscriptions		Royal Management Corp.	**	2,604		2,604	30
31	V	21 Communications		Royal Management Corp.	**				31
32	V	20 Advertising - help wanted		Royal Management Corp.	**	814		814	32
33	V	21 Management allocation - salaries		Royal Management Corp.	**	312,720		312,720	33
34	V	21 Bank charges		Royal Management Corp.	**	3,685		3,685	34
35	V	21 Office supplies & printing		Royal Management Corp.	**	6,963		6,963	35
36	V	21 Postage		Royal Management Corp.	**	2,221		2,221	36
37	V								37
38	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.							38
39	Total		\$			\$ 454,094	\$ *	454,094	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Telephone	\$	Royal Management Corp.	**	\$ 5,313	\$ 5,313	
16	V	24 Travel & seminar		Royal Management Corp.	**	423	423	
17	V	25 Auto expense		Royal Management Corp.	**	14,431	14,431	
18	V	26 Insurance general		Royal Management Corp.	**	2,222	2,222	
19	V	27 Management allocation - employee benefits		Royal Management Corp.	**	43,700	43,700	
20	V	30 Depreciation		Royal Management Corp.	**	35,900	35,900	
21	V	32 Interest		Royal Management Corp.	**	13,352	13,352	
22	V	32 Amortization of mortgage costs		Royal Management Corp.	**	21	21	
23	V	33 Property taxes		Royal Management Corp.	**	2,304	2,304	
24	V	34 Rent expense		Royal Management Corp.	**	2,716	2,716	
25	V	35 Equipment rental		Royal Management Corp.	**	654	654	
26	V	17 Management fees	843,966	Royal Management Corp.	**		(843,966)	
27	V	35 Auto Lease		Royal Management Corp.	**	2,382	2,382	
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% or Royal Management Corp.						
38	V							
39	Total		\$ 843,966			\$ 123,418	\$ * (720,548)	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	16.66	See Schedule 7A	2.54	5.10	Salary	\$ 13,469	L 17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	16.67	See Schedule 7A	2.54	5.10	Salary	13,469	L 17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	16.67	See Schedule 7A	2.54	5.10	Salary	13,469	L 17, C7	3
4	Daniel Thiem	Staff Accountant	Accounting	0.00	See Schedule 7A	0.45	0.91	Salary	936	L 21, C7	4
5	Jason Samatas	Officer	Admin/SNF Ops	0.00	See Schedule 7A	3.63	7.00	Salary	13,257	LC 17,21C7	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 54,600		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Royal Management Corp.
Related Party Compensation
Period: 01/01/08 - 12/31/08

Schedule 7A

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives and Member of the Board of Directors.

Compensation Received From Other Nursing Homes

<u>Facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>Daniel Thiem</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Lombard, Inc.	20,808	20,808	20,808	1,447	20,481	84,352
Lexington Health Care Center of Bloomingdale, Inc.	15,420	15,420	15,420	1,072	15,178	62,510
Lexington Health Care Center of Schaumburg, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Chicago Ridge, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Streamwood, Inc.	19,879	19,879	19,879	1,382	19,566	80,585
Lexington Health Care Center of Elmhurst, Inc.	13,469	13,469	13,469	936	13,257	54,600
Lexington Health Care Center of Lake Zurich, Inc.	19,415	19,415	19,415	1,350	19,109	78,704
Lexington Health Care Center of Orland Park, Inc.	25,825	25,825	25,825	1,795	25,418	104,688
Lexington Health Care Center of Wheeling, Inc.	19,972	19,972	19,972	1,389	19,658	80,963
Lexington Health Care Center of LaGrange, Inc.	11,054	11,054	11,054	769	10,880	44,811
Total	185,600	185,600	185,600	12,904	182,679	752,383

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Royal Management Corp.
 Street Address 665 W. North Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping supplies	Bed Days	731,268	10	\$ 4,564	\$ 53,070	\$ 331	1	
2	5	Utilities - gas & electric	Bed Days	731,268	10	56,094	53,070	4,071	2	
3	5	Utilities - water & sewer	Bed Days	731,268	10	1,425	53,070	103	3	
4	5	Utilities - maintenance office	Bed Days	731,268	10	9,903	53,070	719	4	
5	6	Management allocation - salaries	Bed Days	731,268	10	411,084	411,084	53,070	29,833	5
6	6	Repairs & maintenance	Bed Days	731,268	10	48,773	53,070	3,540	6	
7	6	Scavenger & exterminating	Bed Days	731,268	10	2,504	53,070	182	7	
8	6	Security service	Bed Days	731,268	10		53,070	0	8	
9	7	Management allocation - employee	Bed Days	731,268	10	50,217	53,070	3,644	9	
10	10	Medical consultant	Bed Days	731,268	10	43,800	53,070	3,179	10	
11	10	Management allocation - salaries	Bed Days	731,268	10	245,385	245,385	53,070	17,808	11
12	15	Management allocation - employee	Bed Days	731,268	10	29,975	53,070	2,175	12	
13	17	Management allocation - salaries	Bed Days	731,268	10	556,800	556,800	53,070	40,408	13
14	19	Computer consultant & supplies	Bed Days	731,268	10	210,020	53,070	15,242	14	
15	19	Professional fees	Bed Days	731,268	10	53,093	53,070	3,853	15	
16	20	Dues & subscriptions	Bed Days	731,268	10	35,880	53,070	2,604	16	
17	21	Communications	Bed Days	731,268	10		53,070	0	17	
18	20	Advertising - help wanted	Bed Days	731,268	10	11,214	53,070	814	18	
19	21	Management allocation - salaries	Bed Days	731,268	10	4,309,068	4,309,068	53,070	312,720	19
20	21	Bank charges	Bed Days	731,268	10	50,778	53,070	3,685	20	
21	21	Office supplies & printing	Bed Days	731,268	10	95,951	53,070	6,963	21	
22	21	Postage	Bed Days	731,268	10	30,589	53,070	2,220	22	
23	21	Telephone	Bed Days	731,268	10	73,204	53,070	5,313	23	
24	24	Travel and Seminar	Bed Days	731,268	10	5,826	53,070	423	24	
25	TOTALS					\$ 6,336,147	\$ 5,522,337	\$ 459,830	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317 Report Period Beginning: 01/01/2008

Ending: 12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Royal Management Corp.
 Street Address 665 W. North Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	731,268	10	\$ 198,854	\$ 53,070	\$ 14,431	1
2	26	Insurance general	Bed Days	731,268	10	30,619	53,070	2,222	2
3	27	Management allocation - employee	Bed Days	731,268	10	602,157	53,070	43,700	3
4	30	Depreciation	Bed Days	731,268	10	494,680	53,070	35,900	4
5	32	Interest	Bed Days	731,268	10	183,980	53,070	13,352	5
6	32	Amortization of mortgage costs	Bed Days	731,268	10	283	53,070	21	6
7	33	Property taxes	Bed Days	731,268	10	31,746	53,070	2,304	7
8	34	Rent expense	Bed Days	731,268	10	37,431	53,070	2,716	8
9	35	Equipment rental	Bed Days	731,268	10	9,010	53,070	654	9
10	35	Auto Lease	Bed Days	731,268	10	32,828	53,070	2,382	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,621,588	\$	\$ 117,682	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lexington Financial Services	X		Mortgage	Varies	4/30/07	\$ 16,336,000	\$ 13,489,206	5/1/17	0.0625	\$ 851,571	1								
2	II, L.L.C											2								
3												3								
4												4								
5							Interest on financing insurance premium				1,872	5								
Working Capital																				
6												6								
7	JP Morgan Chase		X	Line of Credit	Various	4/30/07	600,000	500,000	5/1/10	Libor	17,974	7								
8												8								
9	TOTAL Facility Related						\$ 16,936,000	\$ 13,989,206			\$ 871,417	9								
B. Non-Facility Related*																				
10							Interest Income Offset				(304,346)	10								
11							Amortization of loan cost				3,071	11								
12							Allocated from Home Office				13,352	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (287,923)	14								
15	TOTALS (line 9+line14)						\$ 16,936,000	\$ 13,989,206			\$ 583,494	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-14-317-008</u>	<u>Land & Building</u>	\$ <u>64,014.94</u>	\$ <u>64,014.94</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>174,993.86</u>	\$ <u>2,304.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>239,008.80</u>	\$ <u>66,318.94</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community: 342 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>55,000</u>	<u>1991</u>	<u>\$ 1,277,670</u>	<u>1</u>
2	<u>Allocated from management company</u>			<u>11,790</u>	<u>2</u>
3	TOTALS	55,000		\$ 1,289,460	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	133	1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 2,009,340	4
5	10	1995	1995	73,302	2,095	35	2,095		28,602	5
6	2	2001	2001							6
7										7
8										8
	Improvement Type**									
9	Building Improvement		1992	693	20	35	20		322	9
10	Land Improvement		1995	7,500	500	15	500		6,667	10
11	Fan Coil Units		1996	4,904	140	35	140		1,751	11
12	Patio		1996	2,322	155	15	155		1,935	12
13	Basement rehab		1997	17,151		10			17,151	13
14	Baseboards		1997	3,129		10			3,129	14
15	Wiring		1998	3,090	155	10	155		3,090	15
16	Lobby Tile		1999	19,354	1,935	10	1,935		19,192	16
17	Patio		1999	4,196	280	15	280		2,518	17
18	Automatic Door		2000	1,300	130	10	130		1,105	18
19	Wallpaper		2000	6,853	685	10	685		5,825	19
20	Patio		2000	1,242	83	15	83		704	20
21	Storage closet for HVAC		2000	3,745	250	15	250		2,122	21
22	Fire pump system		2001	4,140	414	10	414		3,105	22
23	Door releases		2001	4,420	442	10	442		3,315	23
24	Infrared curtains for elevators		2001	3,000	300	10	300		2,250	24
25	Parking lot		2002	2,532	253	10	253		1,772	25
26	Kitchen tile and plumbing		2002	9,661	966	10	966		6,441	26
27	Elevator upgrade		2002	2,596		5			2,596	27
28	Facility Rehab-Painting/wallpaper/carpeting		2003	175,251	17,525	10	17,525		103,690	28
29	Facility Rehab-Floor tile/room upgrade		2003	38,140	1,907	20	1,907		11,283	29
30	Facility Rehab-Carpeting		2003	7,861	786	10	786		4,585	30
31	Parking lot		2004	2,000	400	5	400		1,733	31
32	Roof		2004	15,000	750	20	750		3,313	32
33	Landscaping		2005	5,396	270	20	270		944	33
34	Paint for building		2005	9,000	900	10	900		2,925	34
35	Roof		2005	14,300	715	20	715		2,264	35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HVAC upgrade	2005	\$ 3,230	\$ 162	20	\$ 162		\$ 593	37
38	Sprinkler system	2005	1,060	53	20	53		172	38
39	Lobby, lounge and reception rehabilitation	2005	27,602	1,380	20	1,380		5,405	39
40	Window treatment	2005	1,932	193	10	193		708	40
41	Cubicle curtains	2005	820	164	5	164		547	41
42	Countertop	2005	845	169	5	169		620	42
43	HVAC	2006	3,793	190	20	190		395	43
44	Automatic Door Lock	2006	2,784	139	20	139		278	44
45	Storeroom Door Lock	2006	1,904	95	20	95		206	45
46	Service Door	2006	2,545	127	20	127		254	46
47	Landscaping Enhancement-Patio	2006	2,340	156	15	156		377	47
48	PT Therapy Room	2006	570	14	40	14		28	48
49									49
50									50
51									51
52	Transitional Unit	2007	1,864	93	20	93		163	52
53	Employee Lunch Room	2007	2,827	141	20	141		212	53
54	PT Room Rehab	2007	58,628	2,941	20	2,941		3,728	54
55	Landscaping-brick pavers	2008	43,813	730	15	730		730	55
56	Parking Lot	2008	31,700	925	20	925		925	56
57	Roof Repairs	2008	4,200	187	15	187		187	57
58	HVAC-New Chillers	2008	118,557	1,976	20	1,976		1,976	58
59	Emergency A/C	2008	5,706	95	20	95		95	59
60	Building Addition	2008	379,699		27	2,301	2,301	2,301	60
61	Kitchen Upgrade	2008	7,214		27	44	44	44	61
62	2nd Floor Remodel-painting, flooring, electrical	2008	561,274		27	3,402	3,402	3,402	62
63	Foundation Stabilization	2008	66,195		27	401	401	401	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,883,765	\$ 41,986		\$ 165,579	\$ 123,593	\$ 2,277,416	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,883,765	\$ 41,986		\$ 165,579	\$ 123,593	\$ 2,277,416	1
2									2
3									3
4									4
5									5
6									6
7	Land improvements - management company	2002	18,582		15	1,286	1,286	7,362	7
8	Building - management company	2002	144,570		40	28,062	28,062	26,335	8
9	HVAC, electrical, security system - management company	2003	1,433		30	55	55	437	9
10	Key card system - management company	2004	225		20	10	10	39	10
11	VAV TX controls - management company	2005	69		20	7	7	10	11
12	Interior Signs- management company	2006	50		5	6	6	6	12
13	Building - management company	2008	30		5	5	5	5	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,048,724	\$ 41,986		\$ 195,010	\$ 153,024	\$ 2,311,610	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 316,488	\$ 51,939	\$ 51,939	\$	5	\$ 160,358	71
72	Current Year Purchases	411,430	3,642	15,138	11,496	5	15,138	72
73	Fully Depreciated Assets	23,203					23,203	73
74	Allocated from Management Company	185,126		3,023	3,023		113,349	74
75	TOTALS	\$ 936,247	\$ 55,581	\$ 70,100	\$ 14,519		\$ 312,048	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Management Company			26,460		3,446	3,446		17,347	79
80	TOTALS			\$ 26,460	\$	\$ 3,446	\$ 3,446		\$ 17,347	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,300,891	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,567	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 268,556	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 170,989	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,641,005	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	3rd Floor Remodel	\$ 252,038	92
93			93
94			94
95		\$ 252,038	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from management company</u>				<u>2,716</u>			6
7	TOTAL				\$ <u>2,716</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 44,747 Description: Copier- \$7054; Mailing System- \$180; Medical Equip- \$19,231; Oxygen- \$17,628; Alloc Mgmt Co. \$654

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	<u>Allocated from management company</u>			<u>2,382</u>	20
21	TOTAL		\$	\$ <u>2,382</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	4,061	\$ 268,892	\$	4,061	\$ 268,892	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,371	74,889		1,371	74,889	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		5,167	370,523		5,167	370,523	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				242,532		242,532	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	L39, C3				953			953	12
13	Other (specify): <u>Dentist</u>	L39, C3				863			863	13
14	TOTAL			\$	10,599	\$ 716,120	\$ 242,532	10,599	\$ 958,652	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 344,274	\$ 345,679	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>463,613</u>)	1,764,098	1,764,098	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,140	29,140	6
7	Other Prepaid Expenses	11,819	11,819	7
8	Accounts Receivable (owners or related parties)	8,888	9,549,707	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,158,219	\$ 11,700,443	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	18,603	18,603	12
13	Land		1,289,460	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	758,796	1,938,138	15
16	Equipment, at Historical Cost	390,272	962,707	16
17	Accumulated Depreciation (book methods)	(437,594)	(2,641,005)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>CIP</u>)	252,038	252,038	22
23	Other(specify): <u>Mortgage Cost-Net</u>		80,290	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 982,115	\$ 6,010,817	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,140,334	\$ 17,711,260	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 331,439	\$ 331,439	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	302,726	302,726	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,713	7,713	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,000	32
33	Accrued Interest Payable		70,913	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached Sch 17A</u>	502,225	1,358,777	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,644,103	\$ 2,637,568	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,489,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 13,489,206	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,644,103	\$ 16,126,774	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,496,231	\$ 1,584,486	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,140,334	\$ 17,711,260	48

Lexington Health Care Center of Elmhurst, Inc.

Provider #0037317

1/1/08-12/31/08

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other current liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from SB Elm Remodel	(139,895)	(139,895)
Due to Royal	(30,126)	(30,126)
Due from Bloomingdale	(1,048)	(1,048)
Due from Chicago Ridge	(523)	(523)
Accrued 401K	(18,523)	(18,523)
Due to Republic Construction	(22,476)	(22,476)
Accrued Expenses	(71,159)	(71,159)
Accrued Royal Gen Mgmt Fees	(27,191)	(27,191)
Deferred Income	(156,935)	(156,935)
Accrued Rent	(34,349)	-
Interest Rate Swap Liability		(890,901)
	<u>(502,225)</u>	<u>(1,358,777)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,206,854	1
2	Restatements (describe):		2
3	Post closing adjustment	(756,971)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 449,883	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,046,348	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,046,348	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,496,231	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,541,846	1
2	Discounts and Allowances for all Levels	(1,349,007)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,192,839	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,568,124	6
7	Oxygen	9,636	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,577,760	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,917	12
13	Barber and Beauty Care	26,366	13
14	Non-Patient Meals	4	14
15	Telephone, Television and Radio	1	15
16	Rental of Facility Space		16
17	Sale of Drugs	280,940	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,205	19
20	Radiology and X-Ray	6,215	20
21	Other Medical Services	134,288	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 472,936	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,920	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,920	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income/Investment Income</u>	701	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 701	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,246,156	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,386,730	31
32	Health Care	4,092,008	32
33	General Administration	2,163,131	33
	B. Capital Expense		
34	Ownership	1,161,521	34
	C. Ancillary Expense		
35	Special Cost Centers	316,813	35
36	Provider Participation Fee	79,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,199,808	40
41	Income before Income Taxes (line 30 minus line 40)**	1,046,348	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,046,348	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This is cash basis tax payer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,880	1,952	\$ 87,809	\$ 44.98	1
2	Assistant Director of Nursing	4,282	4,398	153,990	35.01	2
3	Registered Nurses	33,089	35,865	1,117,837	31.17	3
4	Licensed Practical Nurses	7,844	8,789	227,858	25.93	4
5	CNAs & Orderlies	72,726	77,853	983,123	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,855	8,476	110,363	13.02	8
9	Activity Director	1,825	1,932	32,800	16.98	9
10	Activity Assistants	16,066	17,376	182,210	10.49	10
11	Social Service Workers	6,203	6,425	108,284	16.85	11
12	Dietician	1,884	1,971	32,961	16.72	12
13	Food Service Supervisor	1,577	1,839	33,994	18.49	13
14	Head Cook	1,796	1,971	30,852	15.65	14
15	Cook Helpers/Assistants	13,094	13,934	131,904	9.47	15
16	Dishwashers	12,335	13,067	115,532	8.84	16
17	Maintenance Workers	1,964	2,226	38,695	17.38	17
18	Housekeepers	26,810	28,864	251,705	8.72	18
19	Laundry	8,554	9,105	72,949	8.01	19
20	Administrator	1,927	2,141	100,540	46.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,081	14,326	181,058	12.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	935	1,016	15,774	15.53	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Financial Coordin</u>	3,451	3,780	44,894	11.88	33
34	TOTAL (lines 1 - 33)	239,178	257,306	\$ 4,055,132 *	\$ 15.76	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	229	\$ 13,317	L1, C3	35
36	Medical Director	Monthly	46,875	L9, C3	36
37	Medical Records Consultant	25	1,392	L10,C3	37
38	Nurse Consultant	24	1,317	L10,C3	38
39	Pharmacist Consultant	Monthly	3,505	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	120	5,779	L11,C3	44
45	Social Service Consultant	106	5,309	L12,C3	45
46	Other(specify) <u>Psychosocial</u>	44	2,112	L12,C3	46
47	<u>Medical Consultanat</u>	Monthly	3,179	L10,C7	47
48					48
49	TOTAL (lines 35 - 48)	548	\$ 82,785		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,909	\$ 76,405	L10,C3	50
51	Licensed Practical Nurses	850	29,315	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,759	\$ 105,720		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Conniff	Administrator	0%	\$ 100,540	Workers' Compensation Insurance	\$ 55,563	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	87,151	Advertising: Employee Recruitment	11,062	
				FICA Taxes	299,043	Health Care Worker Background Check		
				Employee Health Insurance	134,365	(Indicate # of checks performed <u>72</u>)	471	
				Employee Meals	11,582	Patient Background Checks	1,529	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	2,103	
				401K Contribution	18,523	Miscellaneous Dues & Subscriptions	3,143	
				Employee Life Insurance	34,157			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,540			Allocated from Mgmt. Co.	3,193	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees (eliminated in column 7)			\$ 843,966			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 843,966	TOTAL (agree to Schedule V, line 22, col.8)	\$ 640,384	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,496	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Grabowski Law Center	Collections		\$ 9,661				Out-of-State Travel	\$
Cassidy Schade, LLP	Legal		51,995					
Freedman Anselmo & Lindberg	Legal		60				In-State Travel	
ING Life Insurance & Annuity	401K Administration		720					
James Samatas	Legal		100				Seminar Expense	7,505
McGladrey & Pullen, LLP	Accounting		19,159	N/A			Allocated from Mgmt Co.	423
Personnel Planners	U/C Consulting		1,330					
Reed Smith/Sachnoff & Weaver	Legal		6,001				Entertainment Expense	()
Royal Management	Pension Administrators		14,229				(agree to Sch. V, line 24, col. 8)	
RSM McGladrey	Accounting		8,643				TOTAL	\$ 7,928
See attached schedule 21C			28,208					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 140,107	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Elmhurst, Inc.
 Provider # 0037317
 1/1/08-12/31/08

Schedule 21C

XIX. Support Schedules
 C. Professional Services

Vendor/Payee	Type	Amount
Gene Whitehorn	Medicaid Reimbursement Specialist	957
Conrac Healthcare	Regulator Consultant	390
Action Computer Service	Computer Consulting	259
Converged Comm	Computer Consulting	140
Lintech LLC	Computer Consulting	5,468
National Datacare	Computer Consulting	1,336
E-Health Data Solutions	Computer Consulting	2,400
C.D.W. Direct	Computer Consulting	324
Krakau Business	Computer Consulting	136
Healthware consulting	Computer Consulting	2,060
Alperian Technology	Computer Consulting	215
Information Control	Computer Consulting	1,044
Silverchair Learning Systems	Computer Consulting	4,300
Microsoft License	Computer Consulting	4,389
Vision Share	Computer Consulting	580
B2B Computer Products	Computer Consulting	1,665
Labor	Computer Consulting	712
Lanac/GP	Computer Consulting	1,835
Total, Other Professional Services		<u>28,208</u>
Total Agrees to Schedule V, Line 19, Column 3		140,107
Allocated from Management Co.		
James Samatas	Legal-filing fees	19
Sachnoff & Weaver	Legal	1,025
Duane Morris	Legal	8
McGladrey & Pullen LLP	Accounting	278
RSM McGladrey	Accounting	295
Aronberg, Goldgehn Davis	Accounting	-
Gilson Labus & Silverman	Accounting	1,099
Pension Administrators, Inc.	401(k) Administration	309
Personnel Planners	Unemployment Consultant	22
Beth Schwarz	Operations Consultant	12
Gene Whitehorn	Medicaid Reim Specialist	568
Computer-See attached schedule	Computer Consulting	15,242
		<u>18,877</u>
Non-allowable accounting Mgmt Co.		(875)
Allocated from Samvest of Lombard II		
Gilson, Labus & Silverman	Accounting	218
Allocated from Building Partnership		
James Samatas	Filing and Recording Fees	100
James Samatas	Filing and Recording Fees	100
		<u>200</u>
Nonallowable Legal Fees		
Grawbowski Law Center, LLC	Legal-Collections	(9,661)
Out of period		(5,859)
		<u>(15,520)</u>
Total, Agrees to Schedule V, Line 19, Column 8		143,007

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/01/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,209 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,605
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 11,582 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees